DRAFT

Charter for the
Cultural and Linguistic Competence Steering Committee
Office of Cultural and Linguistic Competence

The Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) calls for increased cultural and linguistic competence in Virginia's behavioral health care system. It is essential that all aspects of DMHMRSAS be reflective of the diversity of the communities that we serve and that system stakeholders strive to become and remain culturally and linguistically competent. This requires incorporating skills, attitudes, and policies to ensure that the behavioral health care system is effectively addressing the needs of consumers and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, and language. The DMHMRSAS advocates that all stakeholders be trained to reflect cultural and linguistic diversity as a basic civil right (USDOJ, 1964)

Background

The Office of Cultural and Linguistic Competence (OCLC) has been formed in response to the demographic changes among racially, ethnically, culturally and linguistically diverse populations within the Commonwealth of Virginia. These changes are expected to challenge Virginia's behavioral health care system, where addressing their diverse behavioral health care needs has become a Department goal. A recent report of the Surgeon General notes that, to maximize effectiveness, behavioral health care providers must understand better the culture of their patients, and the impact of cultural beliefs and practices on a patient's access and quality of care. Access and quality of care can be affected by the degree to which the behavioral health care system provides culturally and linguistically competent services.

As a result, the need for cultural and linguistic competency standards in behavioral health care programs increasingly has been recognized in order to provide for the sensitive and appropriate assessment and treatment of persons with behavioral health, intellectual disability and substance abuse illnesses from diverse backgrounds (USDHHS, 1999; NIMH, 2001). This requires a thorough understanding of the culture and language of substantial limited English-speaking communities (MHA 2006) and also of the deaf, sexual minority and elder communities. In behavioral health care organizations, cultural and linguistic competence translates into improvement in quality health care (OMH, 2001). As Virginia's population continues to diversify, its overall behavioral health care system needs to be ready to provide cultural and linguistic competency effectively. The DMHMRSAS vision for culturally and linguistically competent care is:

- Care that is given with the understanding of and respect for consumer's health-related beliefs and cultural values; and
- Staff that respect health related beliefs, interpersonal styles, and attitudes and behaviors of the consumers, patients, families, and communities they serve; and
- Leadership from administrative, management and clinical operations that includes individualized assessments; and processes that result in leadership and clinical workforce who are culturally and linguistically competent.

Definitions

Culture: The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (OMH, 2001; NIMH, 2001).

Cultural Awareness: Developing sensitivity and understanding of diverse groups involving internal changes in terms of attitudes and values (Adams, 1995).

Cultural Blindness – Those who profess that culture, race, and/or language make no difference. Individuals and organizations at this point on the continuum actively seek to be nonbiased but in so doing may fail to adequately address the needs of the clients that they serve and implicitly or explicitly encourage assimilation (Cross, et al. 1989).

Cultural Destructiveness – Those operating destructively hold beliefs or engage in behaviors that reinforce the superiority of one race or culture over another with the resultant oppression of the group viewed as inferior (Cross, et al. 1989).

Cultural Diversity: The differences between people based on a shared ideology and valued set of beliefs, norms, customs, and meanings evidenced in a way of life (American Nurses Association, 1986).

Cultural Incapacity – Those operating at the point of cultural incapacity are less actively destructive but behave paternalistically, lack the skills to be effective with individuals from diverse groups, and often reinforce biased policies (Cross, et al. 1989).

Cultural Knowledge: Familiarization with selected cultural characteristics, history, values, belief systems, and behaviors of the members of another ethnic group (Adams, 1995).

Cultural Sensitivity: Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences (National Maternal and Child Health Center on Cultural Competency [NCCC], 1997).

Cultural Skill: A skill-set to access an individual's background and formulate a treatment plan that is culturally relevant (Campinha-Bacote, 1994).

Cultural Precompetence – Although the need for culturally competent policies, procedures, and people is recognized, it may not extend beyond tokenism or a search for ways to respond (Cross, et al. 1989).

Cultural Competence in Behavioral health: A set of compatible behaviors, attitudes, and policies that work together in a system, agency, or among professionals that makes possible effective work in cross-cultural situations (Cross, et al. 1989; Isaacs and Benjamin, 1991). Is the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cross, et al. 1989).

Cultural Competency in Behavioral health: The acceptance and respect for difference, continuing self assessment regarding one's own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations (Cross, Brazron, Dennis, & Isaacs. 1998

Culturally and Linguistically Appropriate Services: The ability of behavioral health care providers to understand and respond to the cultural and linguistic needs brought by patients to the health care encounter.

Cultural Proficiency – individuals and organizations seek to refine their approach and practice by learning more about diverse groups through research, dissemination, and a fully integrated workforce (Cross, et al. 1989).

Limited-English Proficiency: Individuals who do not speak English as their native language and who have a limited ability to read, speak, or understand English.

Linguistic Competence: The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.

The OCLC adopts the National Center for Cultural Competence conceptual framework and model based on the work of Cross et al. (1989) for achieving a cultural and linguistic competent health care system. The OCLC shall establish and work with a steering committee to help in the development and implementation of a statewide CLC initiative as follows:

ARTICLE I - NAME, PURPOSE

Section 1: The name of the committee shall be the CLC Steering Committee (CLCSC).

Section2 The purpose of the CLCSC is to support the efforts of the Office of Cultural and Linguistic Competence in order to provide improved services to multicultural consumers and work toward eliminating disparities within the state's behavioral health, intellectual disability and substance-use disorder system. Specifically, the CLCSC assists the Office in strategic planning, establishing committees to accomplish the Office's activities, including financial, personnel, workforce development, fundraising and planning functions. Through such committees, the CLCSC assists the Office in policy formation, monitors the process pf the strategic plan(s), and provides counsel.

ARTICLE II – MISSION, AIMS AND GOALS

Section 1: The mission of the CLCSC is to work with the Office of Cultural and Linguistic Competence to enhance the ability of Virginia's behavioral health care system to effectively deliver linguistically appropriate and culturally competent health care to Virginia's populations.

Section 2: The aim of the CLCSC is to analyze and make recommendations to the Director of the Office of Cultural and Linguistic competency regarding issues related to policies and procedures that will enhance the Department's ability to provide a culturally and linguistically competent system of care.

Section 3: The CLCSC goals are to :

- Adopt and disseminate the OCLC vision statement.
- Encourage and support opportunities for private providers, community service boards, community organizations, consumers, family organizations and DMHMRSAS staff to become partners in the steering committee.
- Support the OCLC by developing and defining a set of values and principles, administrative policies that may enable stakeholders to work effectively cross-culturally.
- Work with the OCLC in order to make recommendations aimed at expanding the number of culturally and linguistically competent service providers, stakeholders, and staff within the public and private sector.
- Identify issues and provide technical support for addressing language access needs.
- Assist the OCLC in developing a state plan to incorporate cultural competence as a critical component in key management activities including planning, quality management, contracts and staff training.
- Assist in the development of statewide technical assistance and workforce training.
- Provide legislative and policy expertise to enhance accessibility and capacity for successful recovery, self-determination, and empowerment of diverse populations.
- Identify relevant data elements needed to report program and service outcomes, measures, and identify progress.

ARTICLE III – MEMBERSHIP AND MEETINGS OF MEMBERS

Section 1: Appointed by the Commissioner of the DMHMRSAS, the CLCSC members are a group of stakeholders who represent diverse interests of the community that serve or advocate for persons with behavioral health, intellectual disability and substance abuse disorders who respect all people's race, religion, ethnicity, gender, age, socioeconomic status, sexual orientation and ability and should not allow differences to affect a person's opportunities

Section 2: Terms: All CLSC members shall serve three-year terms, but are eligible for re-appointment.

Section 3: Leadership: The director of the Office is the facilitator of the CLCSC. CLCSC membership is a sound investment in Virginia's DMHMRSAS and shows community, peers and political

leadership that CLCSC members are committed to advocacy, professionalism and to quality care. Using the Commissioner's philosophical example of shared leadership, the CLCSC consists of affiliates, stakeholders, advocacy agents, and individuals throughout the State that work in committees and subgroups to complete the initiatives of the Office.

Section 4: Vacancies: When a vacancy on the CLCSC exists, nominations for new members may be received from present CLCSC members and the Office in advance of a CLCSC meeting. These nominations shall be sent out to the CLCSC members with the regular Committee meeting announcement, to be voted upon at the next CLCSC meeting.

Section 5: Resignation, Termination and Absences. Resignation from the CLCSC must be in writing and received by the Office. If a member represents an organization and the person is no longer eligible to serve, that organization may nominate a replacement member according to Article III, Section 4. If an organization notifies the Office that their representative who serves on the CLCSC no longer represents the organization, the person is no longer eligible to be a member of the CLCSC.

Section 6: Regular Meetings. The date of the regular meeting shall be set by the Office which also shall set the time and place. During the CLCSC meetings, the Office will brief members on changes to the CLC program, new initiatives, legislative and budget developments, and DMHMRSAS administrative issues. In addition, the CLCSC provides for a public comment period in order to hear from the general public regarding any CLC related issues.
Special Meetings. Special meeting may be called by the Office or one-third of the CLCSC members.

Section 7: Attendance: This section is intended to support full contribution of all CLCSC members. An attendance problem occurs if any of the following conditions exist in regard to a board member's attendance to board meetings:

1. The member has three un-notified absences in a row ("un-notified" means the member did not call ahead to a reasonable contact in the organization before the upcoming meeting to indicate they would be gone from the upcoming meeting).
2. The member misses one third of the total number of board meetings in a twelve-month period.

If a problem exists regarding a CLCSC member, the Office will promptly contact the member to discuss the problem. The member's response will promptly be shared by the Office with the entire CLCSC at the next regular scheduled meeting. In that meeting, the CLCSC will decide what actions to take regarding the member's future membership on the committee. If the CLCSC decides to terminate the member's membership, termination will be conducted per this policy. The CLCSC will promptly initiate a process to begin recruiting a CLCSC member.

Note: There are some members, who may be affected by compressed work week schedules and required job responsibilities, (i.e. court appearances, Commissioner appointed temporary custody evaluation), which may affect attendance. However, it does not reflect any less commitment or active participation on the CLSC.

Section 8: Notice. Notice of each meeting shall be given to CLSC members, by email, not less than ten days before the meeting, unless a special meeting by the Office or one-third of the CLSC members.

ARTICLE IV –Responsibilities

Section 1: Planning:

	Responsibility
Direct the process of planning	CLCSC
Provide input to long range goals	Joint
Approve long range goals	CLCSC
Formulate annual objectives	OCLC
Approve annual objectives	CLCSC
Prepare performance reports on achievement of goals and objectives	OCLC
Monitor achievement of goals and objectives	Joint

Section 2: Programming:

	Responsibility
Assess stakeholder (customers, community) needs	OCLC
Train volunteer leaders (nonprofits only)	OCLC
Oversee evaluation of products, services and programs	CLCSC
Maintain program records; prepare program reports	OCLC
Prepare preliminary budget	OCLC
See that expenditures are within budget during the year	OCLC
Solicit contributions in fundraising campaigns	Joint

Section 3: CLC Steering Committee :

	Responsibility
Appoint committee members	CLCSC
Promote attendance at CLCSC/Committee meetings	Joint
Recruit new CLCSC members	Joint
Plan agenda for CLCSC meetings	Joint
Take minutes at CLCSC meetings	OCLC
Follow-up to insure implementation of CLCSC and Committee decisions	OCLC

ARTICLE V - AMENDMENTS

Section 1: Bylaws may be amended when necessary by a two-thirds majority of the CLCSC. Proposed amendments must be submitted to the Office to be sent out with CLCSC announcements.

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